

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/05/2012	
NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN46310			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/05/12</p> <p>Facility Number: 000471 Provider Number: 155572 AIM Number: 100290390</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Autumn Hills Health and Rehab Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111)</p>			K0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0025 SS=E	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 95 and had a census of 58 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/06/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 openings in a smoke partition, such as a ceiling, were sealed to limit the transfer of smoke. LSC 8.3.1 requires smoke</p>			K0025	<p>K025 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p>		01/16/2012

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	<p>partitions shall limit the transfer of smoke. This deficient practice could affect visitors, staff and an 20 or more residents in the west center smoke compartment where dining and activities facilities were located.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/05/12 at 2:10 p.m., a one inch pipe and a six inch duct penetrating the ceiling of the service water heater room near the maintenance office had not been sealed. The penetrations left one inch gaps into the attic space above. The maintenance director said at the time of observation, he hadn't known the penetrations were unsealed.</p> <p>3.1-19(b)</p>				<p>1) Immediate actions taken for those residents identified: No Residents were identified. 2) How the facility identified other residents: All residents of the facility have the potential to be effected. 3) Measures put into place/ System changes: The gaps around the 1" pipe and 6" pipe were filled using Wallboard joint compound. The 1" pipe was then sealed with Fire Barrier sealant. The 6" pipe was sealed using aluminum Duct tape. 4) How the corrective actions will be monitored: The maintenance supervisor will inspect the area once monthly for 3 months to ensure that the seal remains intact. The results of the monthly inspection will be reviewed at the monthly safety meeting. 5) Date of compliance: 1/16/2012</p>		

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K0029 SS=E	<p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to provide an automatic closer for the door providing access to 1 of 6 hazardous areas such as a combustible materials storage room larger than 50 square feet. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors which close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 20 or more resident in the west center smoke compartment which include physical therapy and dining facilities.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/05/12</p>			K0029	<p>K029</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: No Residents were identified.</p> <p>2) How the facility identified other residents: All residents of the facility have the potential to be effected.</p>		01/16/2012

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K0038 SS=E	<p>at 2:35 p.m., the door separating the nine by twelve foot medical supply storage room did not self close. Upon closer inspection at the time of observation by the maintenance director, he said an arm of the self closing device had been removed.</p> <p>3.1-19(b)</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 exits terminated at a public way such as a street, paved alley or parking lot. LSC Section 19.2.1, Means of Egress Requirements, requires every exit discharge, exit location and access shall be in accordance with LSC Chapter 7. LSC 7-7.1 requires all</p>		K0038	<p>3) Measures put into place/ System changes: The door to the medical supply storage room has been fitted with an automatic door closure device.</p> <p>4) How the corrective actions will be monitored: The maintenance supervisor will inspect the medical supply room door to ensure that the automatic closure is functioning properly once monthly for 3 months. The results of the monthly inspection will be reviewed at the monthly safety meeting.</p> <p>5) Date of compliance: 1/16/2012</p> <p>K038</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p>		02/19/2012	

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	<p>exits shall terminate at a public way. This deficient practice affects staff, visitors and 23 residents on the west wing and in the Medicare suites.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/05/12 at 2:30 p.m., the exit to the outside from the apartments' dining room terminated at a grassy lawn. The surface of the paved drive was located 10 feet from the exit. The maintenance director acknowledged the grassy area would be difficult to evacuate residents over to reach the paved area in bad weather.</p> <p>3.1-19(b)</p>				<p>1) Immediate actions taken for those residents identified: No Residents were identified.</p> <p>2) How the facility identified other residents: All residents of the facility have the potential to be effected.</p> <p>3) Measures put into place/ System changes: A contractor has been employed for a concrete sidewalk that is 21' long 4' wide and 4" thick, that will start at the concrete pad outside the dining room door and terminate at the asphalt drive. The instillation of the sidewalk will be partially dependent on the weather. The temperature must be above freezing to pour concrete, however it will be completed as soon as possible.</p> <p>4) How the corrective actions will be monitored: The maintenance supervisor will supervise the instillation of</p>		

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K0048 SS=B	<p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of the kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ul style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any residents, staff and visitors in the</p>	K0048	<p>the sidewalk and will periodically observe the area for settling and or cracking. Repairs will be made as needed.</p> <p>5) Date of compliance: 2/19/2012</p> <p>K048</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: No Residents were identified.</p> <p>2) How the facility identified other residents: All residents of the facility have the potential to be effected.</p>	01/17/2012	

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	<p>vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of the facility Fire Policy and Procedure on 01/05/12 at 1:20 p.m. with the maintenance director, the plan did not include the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The maintenance director acknowledged at the time of record review, the K class fire extinguisher had not been included as part of the written plan.</p> <p>3.1-19(b)</p>				<p>3) Measures put into place/ System changes: The fire policy and procedure has been updated to include the use of the K-class fire extinguisher. The list of facility fire extinguishers and their locations has also been added to the disaster plan manual.</p> <p>4) How the corrective actions will be monitored: The maintenance supervisor will ensure that the disaster manual is kept up to date and reviewed annually at the January safety meeting.</p> <p>5) Date of compliance: 1/17/2012</p>		

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K0051 SS=E	<p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure a smoke detector connected to the fire alarm system in 2 of 7 smoke compartments was properly separated from an air supply. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect visitors, staff, and 40 or more residents in the North and South smoke compartments.</p> <p>Findings include:</p>			K0051	<p>K051</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: No Residents were identified.</p> <p>2) How the facility identified</p>		01/19/2012

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K0130 SS=E	Based on observations with the maintenance director on 01/05/12 between 12:30 p.m. and 3:45 p.m., corridor smoke detectors were located 12 inches from an air vent near the North hall soiled utility room and 18 inches from an air supply near room 21 on the South hall. The maintenance director confirmed the distance measurements and agreed at the time of observation, the air flow could impede the function of the smoke detectors. 3.1-19(b)			other residents: All residents of the facility have the potential to be effected. 3) Measures put into place/ System changes: The smoke detectors have been relocated and are now at least 3 feet from the air supply. 4) How the corrective actions will be monitored: The results of the monthly inspection will be reviewed at the monthly safety meeting. 5) Date of compliance: 1/19/2012			
	OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review, and interview; the facility failed to ensure 4 of 7 service water heaters had unexpired certificates of inspection. LSC 19.1.1.3 requires all health facilities to be maintained and		K0130	K130 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. 1) Immediate actions taken for		01/24/2012	

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	<p>operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects visitors, staff and 20 or more residents in the West hall and center smoke compartments.</p> <p>Findings include:</p> <p>Based on observation of service water heater rooms with the maintenance director on 01/05/12 between 12:30 p.m. and 3:45 p.m., the posted certificates of inspection had expired on 03/13/11 for water heater # 287339 and # 278897, on 05/20/11 for # 287340, and 10/07/11 for # 308218 in mechanical rooms located on the West hall and center service corridor. The maintenance director said at the time of observation, he had called to request inspections but none had been done.</p> <p>3.1-19(b)</p>				<p>those residents identified: No Residents were identified. 2) How the facility identified other residents: All residents of the facility have the potential to be effected. 3) Measures put into place/ System changes: The facility insurance company has been contacted and the facility is on the list for the inspection. 4) How the corrective actions will be monitored: The maintenance supervisor will maintain a log of boiler inspection dates and order new inspections 3 months before the due date. Will review annually at the November safety meeting. 5) Date of compliance: 1/24/2012</p>		
K0147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2						

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	<p>Based on observation and interview, the facility failed to ensure wet locations in 3 of 7 smoke compartments were provided with GFCI (ground-fault circuit interrupter) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20, Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects visitors staff and 30 or more residents in the West, and two center smoke compartments which include dining and activity rooms.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director on 01/05/12</p>			K0147	<p>K147</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: No Residents were identified.</p> <p>2) How the facility identified other residents:</p> <p>All residents of the facility have the potential to be effected.</p> <p>3) Measures put into place/ System changes: There has been a GFCI installed in each location listed on the 2567.</p> <p>4) How the corrective actions will be monitored:</p> <p>The maintenance supervisor will inspect the area once monthly for 3 months to</p>		01/17/2012

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	<p>between 12:30 p.m. and 3:45 p.m., electrical outlets were not provided with GFCI (ground fault circuit interrupter) protection to prevent electric shock for sinks in the maintenance office bathroom, two public restrooms near the south nurses station, the West nurses station bathroom, the restorative dining room, the employees bathroom near the maintenance office, activities room bathroom, activities room kitchenette, and the West clean utility room. The outlets were located six inches to twenty four inches from the sinks in these locations. The maintenance director agreed at the time of observations, the outlets should have been equipped with GFCI circuit breakers.</p> <p>3.1-19(b)</p>				<p>ensure that the GFCI's are functioning properly. The results of the monthly inspection will be reviewed at the monthly safety meeting.</p> <p>5) Date of compliance: 1/17/2012</p>		